

9666

CERTIFICATE OF DEATH

Reg. Dist. No.

09653
363

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount	
c. LENGTH OF STAY IN 1b 3 months		d. STREET ADDRESS 312 Main St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 Main St.		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle UPSHUR Last BALLARD		4. DATE OF DEATH Month Sept. Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Fairmount, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Ballard		14. MOTHER'S MAIDEN NAME Roseanna Turpin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Henry L. Bradshaw-312 Main St.-Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma bowel; Pancreas 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 years (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Sept , 19 56 , that I last saw the deceased alive on Sept 30 , 19 56 , and that death occurred at 12:04 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 10/1/56			
ACTUAL SIGNATURE C. G. Rawley M.D.		DATE SIGNED 10/1/56	
PHYSICIAN'S NAME (Type) Dr. C. G. Rawley		Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 3, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Marion Station, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR 10/1/56		24b. REGISTRAR'S SIGNATURE Barton S. Nelson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		MARRIAGE [REDACTED]		RELIGION [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		IMMEDIATE CAUSE [REDACTED]		INTERMEDIATE CAUSE [REDACTED]		UNDERLYING CAUSE [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF DEATH REGISTRAR [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	

BUREAU V. S.

OCT 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09654
Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md.			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				d. STREET ADDRESS 995 Union Ave., Bronx, N.Y.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) James Howard First Middle Last				Davenport		4. DATE OF DEATH Month Sept. Day 29 Year 1956									
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3-27-1935		9. AGE (In years last birthday) 21 yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk			10b. KIND OF BUSINESS OR INDUSTRY Meat Packing		11. BIRTHPLACE (State or foreign country) Columbia, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME John Davenport				14. MOTHER'S MAIDEN NAME Bertha Halsey Davenport											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Bertha Davenport, Columbia, N.C.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull—Crushed Chest DUE TO 825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Left Femur DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 0								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car Accident Highway 13 North of Princess Anne												
20c. TIME OF INJURY Month, Day, Year 1:15 a.m. Sept 29 1956			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 13 Princess Anne Somerset Md.		20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>R. H. Johnson</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED								
EXAMINER'S NAME (Type) R. H. Johnson M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Sept 29-1956</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-1956		22c. NAME OF CEMETERY OR CREMATORY Chapel Hill		22d. LOCATION (City, town, or county) (State) Columbia, N.C.									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levin B. Wilson</i>					ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE 10/1/56								
					24b. REGISTRAR'S SIGNATURE <i>R. H. Johnson</i>										

MEDICAL CERTIFICATION

19

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09655

Reg. Dist. No. 260

9670

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE North Carolina b. COUNTY 70x-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Box 86, Columbia, N.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) John Davenport				4. DATE OF DEATH Sept. 29, 1956 19			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Columbia, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary Garrett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Blank]		17. INFORMANT Berthe Davenport, Columbia, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Fracture Both Fore 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arms - Fracture Right Tibia and DUE TO (c) Fibula - Crushed Chest							INTERVAL BETWEEN ONSET AND DEATH 0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car Accident Highway 13 - North of Princess Anne					
20c. TIME OF INJURY Month, Day, Year 1:15 a.m. Sept 29 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 13		20f. (City or town) (County) (State) Princess Anne Somerset Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.H. Johnson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.H. Johnson M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 29 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-1956		22c. NAME OF CEMETERY OR CREMATORY Chapel Hill		22d. LOCATION (City, town, or county) (State) Columbia, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis B. Wilson Princess Anne, Md.				24a. REC'D BY REGISTRAR DATE 10/1/56		24b. REGISTRAR'S SIGNATURE R.H. Johnson, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

10-3-1968 Charles Hill

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9671

CERTIFICATE OF DEATH

Reg. Dist. No.

196556
(09650) 261

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First CARRIE Middle TULL Last DAVIS				4. DATE OF DEATH Month September Day 10 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1872	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel L. Tull				14. MOTHER'S MAIDEN NAME Catherine Gunby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Nathaniel B. Riffin--Marion Station, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis, Chronic Out DUE TO Nephritis (c) General Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1956 , to Sep. 10, 1956 , that I last saw the deceased alive on Sep. 10, 1956 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Marion Sta. Md. DATE SIGNED 9-12-56 ACTUAL SIGNATURE George C. Coulbourne M.D. PHYSICIAN'S NAME (Type) Dr. George C. Coulbourne Marion Station, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Marion Station, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 9-12-56		24b. REGISTRAR'S SIGNATURE Nellie D. Payne	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. 2

SEP 19 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09657	
Items 20&21 Film G204 9-28-56 sms											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9657	
Reg. Dist. No. 265											
1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>					c. LENGTH OF STAY IN 1b <u>2 mos.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 39	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____					d. STREET ADDRESS _____					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Rubin</u> Last <u>Evans</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1956</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1956</u>		9. AGE (In years last birthday) <u>0</u> yrs. <u>2</u> Months <u>1</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Crisfield</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Evans</u>					14. MOTHER'S MAIDEN NAME <u>Loretta Taylor</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Loretta Evans</u> Address <u>Crisfield Som. Co. Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation - Baby was</u> <u>9240</u> DUE TO <u>Sleeping during night between mother & father & mother awoke at 4 AM & Baby was dead</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE, GIVEN IN PART I. (a) <u>William H. Coulbourn, M.D.</u> <u>DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.</u>										INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Same as in No. 18</u>								
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> min <u>0</u> sec <u>during night Sept 15 19 56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home in Bed</u>		20f. City or town <u>Crisfield Somerset Md</u>		(County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>W. H. Coulbourn</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>Sept 15/56</u>	
EXAMINER'S NAME (Type) _____					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17 '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawnsonia</u>			22d. LOCATION (City, town, or county) (State) <u>Crisfield, Som. Co. Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion St., Md.</u>					24a. REC'D BY REGISTRAR <u>9/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>				

100028 XXV.6.

RECEIVED

SEP 20 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09658
260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u>		c. LENGTH OF STAY IN 1b <u>Manokin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>A.</u> Middle <u>Fallon</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manokin, Som. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Zipora (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-308070</u>	
17. INFORMANT <u>Reba Walker Glasburg h, New Jersey</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of jaw -</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		DATE SIGNED <u>Sept 10 - 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Manokin Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta. Md. #235</u>		24a. REC'D BY REGISTRAR DATE <u>9/10/56</u>	
24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

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BUREAU V. S.

ATTENDING PHYSICIAN: The law requires that the
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9673

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCready Hospital</u>		d. STREET ADDRESS <u>Potomac St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JEFFERSON</u> Middle <u>MONROE</u> Last <u>GEOGHEGAN</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Somerset County</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Moses Geoghegan</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Sadie Geoghegan-Potomac St.--Crisfield, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>Angina pectoris</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>25 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>57</u> , to <u>Sept.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 30</u> , 19 <u>56</u> , and that death occurred at <u>8:40</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. G. Rawley</u>		ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. C. G. Rawley</u>		DATE SIGNED <u>10/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>All Saints Episcopal Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Monie, (Somerset County), Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons--Crisfield, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>10/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara S. Brown</u>	

MEDICAL CERTIFICATION

BUREAU V. S.

OCT 4 1956

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9674

CERTIFICATE OF DEATH

Reg. Dist. No. -265-

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital, Crisfield		d. STREET ADDRESS R.F.D. Marion	
3. NAME OF DECEASED (Type or print) First A. Middle Lula Last Horsey		4. DATE OF DEATH Month Sept Day 16 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Stevenson		14. MOTHER'S MAIDEN NAME Aurinthia Miles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT William C. Horsey Jr. Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Acute Dil. of heart 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis - Chronic Int. Nephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 9, 1956 to Sept. 16, 1956 , that I last saw the deceased alive on SEPT. 16, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Coulbourn M.D.		ADDRESS (Street, city or town, state) Marion, Sta. Md. DATE SIGNED 9-17-56	
PHYSICIAN'S NAME (Type) George C. Coulbourn M.D.		MARION STA. MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Sept. 18, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	22d. LOCATION (City, town, or county) (State) Marion, Md. SOMERSET, Co.
23. FUNERAL DIRECTOR'S SIGNATURE James Hannon Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR SEP. 17-1956		24b. REGISTRAR'S SIGNATURE Nellie R. Payne	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

SEP 19 1956

RECEIVED

9675

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Milbourne</u> Last <u>Milbourne</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 16, 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Westover Feed Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kingston, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Milbourne</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Harmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-01-0887</u>	
17. INFORMANT Address <u>Virgie Milbourne Westover, Som. Co. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Carcinomatosis</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 2, 1955</u> to <u>Sept. 7, 1956</u> , that I last saw the deceased alive on <u>Sept. 7, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. C. Lewis</u> M.D.		ADDRESS (Street, city or town, state) <u>Princess Anne, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>A. C. Lewis M.D.</u>		<u>Princess Anne, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept. 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Westover, Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta., Md. #235</u>		24a. REC'D BY REGISTRAR <u>9/10/56</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>R. J. Johnson, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. TIME OF DEATH 2:01 PM		8. CAUSE OF DEATH Shot	
9. MANNER OF DEATH Homicide		10. PLACE OF BIRTH Jackson, Mississippi	
11. DATE OF BIRTH March 24, 1933		12. SIGNATURE OF DECEASED (None)	
13. SIGNATURE OF WITNESS JAMES EARL RAY		14. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
15. SIGNATURE OF CORONER JAMES EARL RAY		16. SIGNATURE OF JURY JAMES EARL RAY	
17. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		18. SIGNATURE OF CLERK JAMES EARL RAY	
19. SIGNATURE OF SHERIFF JAMES EARL RAY		20. SIGNATURE OF JUDGE JAMES EARL RAY	
21. SIGNATURE OF PROSECUTOR JAMES EARL RAY		22. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
23. SIGNATURE OF JURY JAMES EARL RAY		24. SIGNATURE OF JUDGE JAMES EARL RAY	
25. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		26. SIGNATURE OF CLERK JAMES EARL RAY	
27. SIGNATURE OF SHERIFF JAMES EARL RAY		28. SIGNATURE OF JUDGE JAMES EARL RAY	
29. SIGNATURE OF PROSECUTOR JAMES EARL RAY		30. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
31. SIGNATURE OF JURY JAMES EARL RAY		32. SIGNATURE OF JUDGE JAMES EARL RAY	
33. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		34. SIGNATURE OF CLERK JAMES EARL RAY	
35. SIGNATURE OF SHERIFF JAMES EARL RAY		36. SIGNATURE OF JUDGE JAMES EARL RAY	
37. SIGNATURE OF PROSECUTOR JAMES EARL RAY		38. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
39. SIGNATURE OF JURY JAMES EARL RAY		40. SIGNATURE OF JUDGE JAMES EARL RAY	
41. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		42. SIGNATURE OF CLERK JAMES EARL RAY	
43. SIGNATURE OF SHERIFF JAMES EARL RAY		44. SIGNATURE OF JUDGE JAMES EARL RAY	
45. SIGNATURE OF PROSECUTOR JAMES EARL RAY		46. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
47. SIGNATURE OF JURY JAMES EARL RAY		48. SIGNATURE OF JUDGE JAMES EARL RAY	
49. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		50. SIGNATURE OF CLERK JAMES EARL RAY	
51. SIGNATURE OF SHERIFF JAMES EARL RAY		52. SIGNATURE OF JUDGE JAMES EARL RAY	
53. SIGNATURE OF PROSECUTOR JAMES EARL RAY		54. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
55. SIGNATURE OF JURY JAMES EARL RAY		56. SIGNATURE OF JUDGE JAMES EARL RAY	
57. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		58. SIGNATURE OF CLERK JAMES EARL RAY	
59. SIGNATURE OF SHERIFF JAMES EARL RAY		60. SIGNATURE OF JUDGE JAMES EARL RAY	
61. SIGNATURE OF PROSECUTOR JAMES EARL RAY		62. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
63. SIGNATURE OF JURY JAMES EARL RAY		64. SIGNATURE OF JUDGE JAMES EARL RAY	
65. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		66. SIGNATURE OF CLERK JAMES EARL RAY	
67. SIGNATURE OF SHERIFF JAMES EARL RAY		68. SIGNATURE OF JUDGE JAMES EARL RAY	
69. SIGNATURE OF PROSECUTOR JAMES EARL RAY		70. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
71. SIGNATURE OF JURY JAMES EARL RAY		72. SIGNATURE OF JUDGE JAMES EARL RAY	
73. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		74. SIGNATURE OF CLERK JAMES EARL RAY	
75. SIGNATURE OF SHERIFF JAMES EARL RAY		76. SIGNATURE OF JUDGE JAMES EARL RAY	
77. SIGNATURE OF PROSECUTOR JAMES EARL RAY		78. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
79. SIGNATURE OF JURY JAMES EARL RAY		80. SIGNATURE OF JUDGE JAMES EARL RAY	
81. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		82. SIGNATURE OF CLERK JAMES EARL RAY	
83. SIGNATURE OF SHERIFF JAMES EARL RAY		84. SIGNATURE OF JUDGE JAMES EARL RAY	
85. SIGNATURE OF PROSECUTOR JAMES EARL RAY		86. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
87. SIGNATURE OF JURY JAMES EARL RAY		88. SIGNATURE OF JUDGE JAMES EARL RAY	
89. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		90. SIGNATURE OF CLERK JAMES EARL RAY	
91. SIGNATURE OF SHERIFF JAMES EARL RAY		92. SIGNATURE OF JUDGE JAMES EARL RAY	
93. SIGNATURE OF PROSECUTOR JAMES EARL RAY		94. SIGNATURE OF DEFENSE ATTORNEY JAMES EARL RAY	
95. SIGNATURE OF JURY JAMES EARL RAY		96. SIGNATURE OF JUDGE JAMES EARL RAY	
97. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		98. SIGNATURE OF CLERK JAMES EARL RAY	
99. SIGNATURE OF SHERIFF JAMES EARL RAY		100. SIGNATURE OF JUDGE JAMES EARL RAY	

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BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9676

CERTIFICATE OF DEATH

09662

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Since Birth	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FAITH Middle ANN Last MILLS		4. DATE OF DEATH Month Sept. Day 24 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1956
9. AGE (In years lost birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John O. Mills, Jr.		14. MOTHER'S MAIDEN NAME Mary Edith Styles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT J. O. Mills, Jr.		Address 337 Chesapeake Ave.- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplectic (fulminating) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 22, 1956 , to Sept 23, 1956 , that I last saw the deceased alive on Sept 23, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		ADDRESS (Street, city or town, state) 334 W. Main - Crisfield Md DATE SIGNED 9/24/56	
PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton		Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 24, 1956	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 9/26/56 24b. REGISTRAR'S SIGNATURE Barbara L. Adams	

2079262XV2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED
OCT 1 1956
BUREAU V. S.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter discusses the author's recent visit to the United States and his observations on the state of the country. He mentions that he has been very much impressed by the progress of the country and the high level of civilization. He also mentions that he has been very much interested in the work of the American people and the high level of their intelligence. He concludes the letter by expressing his hope that the United States will continue to progress and that the American people will continue to be a source of inspiration to the rest of the world.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9677 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09663

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City d. STREET ADDRESS 130 W. 142 St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Delton Mizell		4. DATE OF DEATH Sept. 29, 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1929
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Smoker		10b. KIND OF BUSINESS OR INDUSTRY Meat Packing	
11. BIRTHPLACE (State or foreign country) Columbia, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Esley Mizell		14. MOTHER'S MAIDEN NAME Pauline Davenport Mizell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Martha Mizell, New York City, N.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Crushed Chest 825X DUE TO (b) Fracture right humerus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Fracture Both Femurs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car accident Highway 13 -	
20c. TIME OF INJURY Month, Day, Year 1:15 p.m. Sept 29, 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 13		20f. (City or town) Princess Anne R.R. Somerset Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. Johnson M.D.		DATE SIGNED September 29-1956	
EXAMINER'S NAME (Type) P.H. Johnson M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-3-1956	22c. NAME OF CEMETERY OR CREMATORY Chapel Hill	22d. LOCATION (City, town, or county) Columbia, N.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		24a. REC'D BY REGISTRAR 10/1/56	24b. REGISTRAR'S SIGNATURE R.S. Johnson, M.D.

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Miss Anna, Md		Female		Colored		1-29-1929	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		New York City		Heart Disease		Natural	
Date of Burial		Place of Burial		Name of Undertaker		Signature of Medical Examiner	
1-30-1929		Columbia, N.C.		C. C. ...		[Signature]	
Name of Physician		Name of Hospital		Name of City		Name of State	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2
 OCT 2 1956
RECEIVED

Bureau of Health Statistics
 1-3-1956
 General Hall

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9678 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09664

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City d. STREET ADDRESS 213-W 139 St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pauline First Middle Mizzell Davenport 4. DATE OF DEATH Sept. 29, 1956 Month Day Year				5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH I-5-1910 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Columbia, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Davenport				14. MOTHER'S MAIDEN NAME Bertha Halsey Davenport			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Bertha Davenport Address Columbia, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Fracture Right DUE TO 825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Humerus - Fracture Right Femur DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car Accident Highway 13 North of Princess Anne			
20c. TIME OF INJURY Month, Day, Year 1:45 a.m. Sept 29 1956				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 13 20f. (City or town) Princess Anne Somerset Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>R. H. Johnson</i> EXAMINER'S NAME (Type) R. H. Johnson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER R. H. Johnson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Chapel Hill	
22d. LOCATION (City, town, or county) Columbia, N.C. (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levin R. Wilson</i> ADDRESS <i>Princess Anne</i>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>R. H. Johnson, M.D.</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Davidson	
Sex		Male	
Age		1-5-1910	
Date of Birth		1-5-1910	
Place of Birth		Columbia, N.C.	
Usual Residence		Columbia, N.C.	
Cause of Death		Sudden	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date		[Date]	

BUREAU V. 3

OCT 2 1956

RECEIVED

9679

CERTIFICATE OF DEATH

Reg. Dist. No. 261-

1. PLACE OF DEATH:

COUNTY Somerset MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in, this place)
 TOWN Marion Station Life
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Marion
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)
Marion Lee Savage
 (Type or Print)

4. DATE OF DEATH:

(Month) (Day) (Year)
9 3 1956

5. SEX:

male
negro

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

July 16, 1889

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

67 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

General work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Marion, Maryland

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME:

Elijah Savage

14. MOTHER'S MAIDEN NAME:

Grace Wilkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

212-16-1603

17. INFORMANT & ADDRESS:

Marion, Maryland Box 234

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492X
Immediate cause

(a) Uremia & Acute Dil. of Heart.

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Uremia Pneumonia -

DUE TO

(c)

Interval Between Onset And Death

2 days

1 wk.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Sep. 2, 1956, to Sep. 3, 1956, that I last saw the deceased

alive on Sep. 3, 1956, and that death occurred at 10:30 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Sep. 6, 1956

NAME OF CEMETERY OR CREMATORY

Kingston Cemetery

LOCATION (City, town, or county)

Kingston - Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

Sep. 4, 1956

REGISTRAR'S SIGNATURE

Mellie D. Payne

24. FUNERAL DIRECTOR

George W. Tilghman

ADDRESS

Marion, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9680

CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY <u>Somerst</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerst</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Hall</u> Last <u>Speights</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1865</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry W. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Whittington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Lawson F. Reichard Westover, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Senility</u> DUE TO (c) <u>Senility</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 19 56</u> to <u>Sept 24 56</u> , that I last saw the deceased alive on <u>Sept 24 56</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. C. Lewis</u>				DATE SIGNED <u>9/26/56</u>			
PHYSICIAN'S NAME (Type) <u>A. C. Lewis</u>				ADDRESS (Street, city or town, state) <u>Princess Anne</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Sept. 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>		22d. LOCATION (City, town, or county) <u>Princess Anne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>			
24a. REC'D BY REGISTRAR <u>R. H. Johnson, M.D.</u>				24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>			
DATE <u>9/27/56</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

SEP 28 1956

RECEIVED

VS. AISME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

OCT 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89667

Reg. Dist. No. 261

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mary White</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>White</u> Last			4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Portsville, Del.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Nancy (Unknown)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-18-223</u>		17. INFORMANT <u>Wilmore F. White</u> Address <u>Marion Sta.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>William H. Coulbourn, M.D.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> DEPUTY MEDICAL EXAMINER <u>HOP SOMERSET COUNTY, MD.</u> (State)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town)</u> (County)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Wm H Coulbourn</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Wm H Coulbourn</u>			DATE SIGNED <u>Sept 13/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Memorial</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Sept. 14, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mellie D. Payne</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. RACE: [illegible]
5. DATE OF BIRTH: [illegible]
6. PLACE OF BIRTH: [illegible]
7. OCCUPATION: [illegible]
8. CAUSE OF DEATH: [illegible]
9. MANNER OF DEATH: [illegible]
10. SIGNATURE OF EXAMINER: [illegible]
11. DATE OF EXAMINATION: [illegible]

BUREAU V. 21

SEP 18 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9682

CERTIFICATE OF DEATH

Reg. Dist. No.

09668
265-

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMATHA Whittington		4. DATE OF DEATH Sept 19 1956	
5. SEX FEMALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT-18-1936
9. AGE (In years last birthday) yrs. 20		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CRISFIELD MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Theola Whittington md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT PERTURBED ARCHIE MARION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5 1/2 months Conception - 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 13 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 18, 1956 to Sept. 19, 1956 , that I last saw the deceased alive on Sept. 19, 1956 , and that death occurred at 1:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Marion Sta. Md. DATE SIGNED 9-20-56	
ACTUAL SIGNATURE George C. Coulbourn MD		PHYSICIAN'S NAME (Type) George C. Coulbourn-MARION Station - MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 20	
22c. NAME OF CEMETERY OR CREMATORY WARD'S MEMORIAL		22d. LOCATION (City, town, or county) (State) SOMERSET, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H Ward		ADDRESS marion md	
24a. REC'D BY REGISTRAR P 211956		24b. REGISTRAR'S SIGNATURE Walter H. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 21 1956

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